STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING _____ B. WING _____	R 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	**2100 MIDWAY ST COLUMBUS, IN 47201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on August 17, 2016. This visit included the PSR to the Investigation of Complaint IN00206249. This visit was in conjunction with the Investigation of Complaints IN00210296, IN00207997 and IN00211313. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00207607 completed on August 17, 2016. Complaint IN00206249 - Corrected Complaint IN00210296 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00207997 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00211313 - Unsubstantiated due to lack of evidence. Complaint IN00207607 - Corrected Survey dates: September 29 and 30, 2016 Facility number: 000058 Provider number: 155133 AIM number: 100283340 Census bed type: SNF/NF: 119 Total: 119 Census payor type: Medicare: 10 Medicaid: 84 Other: 25	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING _____ B. WING _____	R 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	**2100 MIDWAY ST COLUMBUS, IN 47201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Total: 119 Sample: 12 Kindred Transitional Care and Rehabilitation Columbus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and to the PSR to the Investigation of Complaint IN00206249.	{F 000}		
{F9999}	FINAL OBSERVATIONS	{F9999}		